

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Md.</i>		
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <i>Ellicott City</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Schaeffer's Nursing Home</i>		d. STREET ADDRESS <i>225 Severn Ave</i>		
3. NAME OF DECEASED (Type or print) <i>ANNA</i>		First <i>BOSMAN</i>	Middle <i>BENNETT</i>	
4. DATE OF DEATH Month <i>4</i> Day <i>2</i> Year <i>1958</i>		5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. B. DATE OF BIRTH <i>3-27-1893</i>		
9. AGED (In years lost birthday) <i>65 yrs.</i>		10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS. Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Civil Service</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Clerk, N.S. Gov.</i>		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>William F. Bennett</i>		14. MOTHER'S MAIDEN NAME <i>Edith Bosman</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>- - -</i>		
17. INFORMANT <i>Charles Bennett</i>		Address <i>2</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs.</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Annapolis</i> (County) <i>Md.</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>March 31</i> , 19 <i>58</i> , to <i>April 2</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>March 31</i> , 19 <i>58</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Thomas F. Herbert M.D.</i> ADDRESS (Street, city or town, state) <i>96 Church Rd.</i> DATE SIGNED <i>4/2/58</i>				
PHYSICIAN'S NAME (Type) <i>Thomas F. Herbert M.D.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-5-1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Bluff</i>	22d. LOCATION (City, town, or county) <i>Annapolis</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>APR 7 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Rebekah</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU, N.Y.  
RECEIVED  
APR 7 1958

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04662

## 4670 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Ellicott City</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Old Frederick Road</b>		d. STREET ADDRESS <b>Old Frederick Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>CHARLES</b>	Middle <b>W.</b>	Last <b>FUNK</b>	4. DATE OF DEATH	Month <b>April</b>	Day <b>24, 1958</b>	Year <b>19</b>		
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 8, 1898</b>	9. AGE (In years lost birthday) <b>59 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doughnut Corp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Toms Brook Va.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Israel Funk</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Whitmire</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-4019</b>		17. INFORMANT <b>Mrs. Gertrude E. Funk, Ellicott City, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>237X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>RESPIRATORY ARREST</b> DUE TO (c) <b>BRAIN TUMOR</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs -</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>COLUMBIARD</b>		(County) <b>ELLIOTT CITY, MD.</b>	(State) <b>MD.</b>
21. I certify that I attended the deceased from <b>JAN 5, 1958</b> , to <b>APRIL 24, 1958</b> that I last saw the deceased alive on <b>APRIL 24, 1958</b> , and that death occurred at <b>6:50 PM</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Peter V. Thorpe</b>		M.D.		ADDRESS (Street, city or town, state) <b>COLUMBIARD</b>					DATE SIGNED <b>4-25-58</b>
PHYSICIAN'S NAME (Type) <b>PETER V. THORPE, MD</b>		ELLIOTT CITY, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-27-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Good Shepherd</b>		22d. LOCATION (City, town, or county) <b>Ellicott City, Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>PR 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Allie L. Lewis</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
APR 28 1953  
BUREAU U.S.  
DEPARTMENT OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04663

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH								2			
		1. PLACE OF DEATH a. COUNTY <b>Howard</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>				Reg. Dist. No.			
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Daisy</b>				b. COUNTY <b>Howard</b>							
		c. LENGTH OF STAY IN lb <b>10 Years</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Daisy</b>							
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Daisy Road</b>				d. STREET ADDRESS <b>Daisy Road</b>				R.F.D. <b>Woodbine</b>			
		3. NAME OF DECEASED (Type or print) <b>LEILA STULL HAIGHT</b>				First	Middle	Last	4. DATE OF DEATH <b>4-19-58</b>	Month	Doy	Year	
		5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>Sept, 22 1891</b>	9. AGE (in years last birthday) <b>66</b>	yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> Months	11. IF UNDER 24 HRS. <input type="checkbox"/> Dows	12. IF UNDER 24 HRS. <input type="checkbox"/> Hours	13. IF UNDER 24 HRS. <input type="checkbox"/> Min.		
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
		13. FATHER'S NAME <b>Ulysses G. Stull</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Keyser</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Charles F. Haight,</b>			
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				Address <b>Woodbine, Md.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 Min.</b>			
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>974X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)				Strangulation by hanging							
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self strangulation using electric cord tied to rafter in attic</b>		20c. TIME OF INJURY Hour: <b>1.15</b> AM: <b>4-19-58</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) <b>At home</b>		(County) <b>Daisy Howard</b> (State) <b>Md.</b>	
		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		<i>George E. Burgtoft</i>				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4-19-58</b>			
EXAMINER'S NAME (Type)		<b>George E. Burgtoft</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Burial April 22</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Oak Grove</b>		22d. LOCATION (City, town, or county) <b>Glenwood</b>		(State) <b>Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Boyce W. Barber</i>		ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 22 '58</b>		24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>							

BUREAU A-8

APR 22 1963

RECEIVED

1

FOR STATE  
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04664

Item 7, Film G228 4/28/58 fcy

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		4672 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dayton</b>		c. LENGTH OF STAY IN lb		b. COUNTY <b>Arbutus</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Tridelphia Road</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>	
3. NAME OF DECEASED (Type or print) <b>JACOB</b>		First <b>CHARLES</b>	Middle <b>HOWE</b>	Lost	4. DATE OF DEATH <b>April 17 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>July 20, 1934</b>	9. AGE (In years last birthday) <b>23 yrs.</b>	Month IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bond Bakery</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Jacob Howe Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Benny West</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>220-36-7619</b>		17. INFORMANT <b>Benny West</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple traumatic injuries</b>				Address	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>828X</b>		(b)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO  (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Truck ran off road</b>			
20c. TIME OF INJURY Hour <b>12 noon</b> m. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>	
20f. (City or town) <b>Howard</b>				(County) <b>Md.</b>	
(State)				(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE  <i>Russell S. Fisher</i>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/17/58</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/21/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Moreland</b>	
22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE  <i>Frank Robb &amp; Son</i>		ADDRESS <b>28</b>		24a. REC'D BY REGISTRAR DATE <b>APR 22 '58</b>	
				24b. REGISTRAR'S SIGNATURE  <i>John Smith</i>	

RECEIVED  
BUREAU V. S.

APR 22 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4673

## CERTIFICATE OF DEATH

04665

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b>		c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Marriottsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>/</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>BERTHA</b>	Middle <b></b>	Last <b>King</b>	4. DATE OF DEATH <b>April 10, 1958</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Unlored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-8-1885</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>No</b>		11. BIRTHPLACE (State or foreign country) <b>Cooksville, Md</b>	
13. FATHER'S NAME <b>John Smith</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Johnson</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Dennis King, Marriottsville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<b>CARDIAC failure, Atherosclerotic</b> <b>1956</b>			
(b) DUE TO		<b>HEART DISEASE, HYPER TENSION,</b> <b>to</b>			
(c) DUE TO		<b>CEREBRAL HEMORRAGE, RT Hemiplegia</b> <b>April 1958</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> , 19, to <b>10 April 1958</b> , that I last saw the deceased alive on <b>10 April 1958</b> , and that death occurred at <b>12: P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Cooksville, Md</b> DATE SIGNED <b>10 April 58</b>			
ACTUAL SIGNATURE <b>Howard E. Hall</b>		M.D.			
PHYSICIAN'S NAME (Type) <b>Howard E. Hall</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-13-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>West Liberty</b>	
22d. LOCATION (City, town, or county) <b>Alpha, Md</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Elliott City, Md</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>APR 14 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Albert Beach</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - SANITATION

CERTIFICATE OF DEATH

KINE

ANTONIA

CAGGIANO, ANTONIA, MARYLAND  
HORNBECK, MARY, MARYLAND  
CERTIFICATE NUMBER 4-1000000

BUREAU Y. E

APR 14 1958

REGISTRY

81 114468  
31-102

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4674

## CERTIFICATE OF DEATH

Reg. Dist. No.

04666

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kerger Rd.</b>		d. STREET ADDRESS <b>Kerger</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nannie</b>		First <b>A.</b>	Middle <b>.</b>	Lost <b>KUHN</b>	4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>7/10/1886</b>	9. AGE (In years lost birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William C. Mouring</b>		14. MOTHER'S MAIDEN NAME <b>Susan Thortom</b>		12. CITIZEN OF WHAT COUNTRY? <b>Kerger Rd., Ellicott City, Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Joseph E. Kuhn</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b>		CEREBRO-VASCULAR ACCIDENT		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under: lying cause lost. (b)		Hypertensive cardiovascular disease		20 years	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> , to <b>April 16, 1958</b> , that I last saw the deceased alive on <b>April 16, 1958</b> , and that death occurred at <b>1:00 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>P. V. Thorpe</b>		M.D.		ADDRESS (Street, city or town, state) <b>Columbia Road</b> <b>Ellicott City, Md.</b>	
DATE SIGNED <b>4-17-58</b>					
PHYSICIAN'S NAME (Type) <b>Peter V. Thorpe, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/19/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Johns</b>	
22d. LOCATION (City, town, or county) <b>Ellicott City, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham</b>		ADDRESS <b>Ellicott City, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 21 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Albert J. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## HAWAIIAN STATE GOVERNMENT - DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

## CERTIFICATE OF DEATH

HAWAIIAN STATE

BUREAU X  
RECEIVED  
APR 21 1963

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04667

4675

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b>				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Howard</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Ellicott City</b>				d. STREET ADDRESS <b>/ Mayfield</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mayfield</b>																			
3. NAME OF DECEASED (Type or print) <b>WILLIAM F. LEIBOLDT</b>				First	Middle	Last		4. DATE OF DEATH <b>April 15</b>				Month	Day	Year					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-25-1871</b>		9. AGE (In years last birthday) <b>86</b>				IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW 1</b>				17. INFORMANT <b>Mrs. Margaret Carroll, Ellicott City, Md</b>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>CEREBRAL THROM BOEIS</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>36 HRS.</b> <b>1 mth.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4-15</b>				20f. (City or town) <b>ELLIOTT CITY</b>		(County)	(State)				
21. I certify that I attended the deceased from <b>4-12</b> , 19 <b>58</b> , to <b>4-15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4-15</b> , 19 <b>58</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Donald E. Fisher</b> PHYSICIAN'S NAME (Type) <b>DONALD E. FISHER MD</b>												ADDRESS (Street, city or town, state) <b>ELLIOTT CITY</b>		DATE SIGNED <b>4-17-58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4-19-58</b>				22c. NAME OF CEMETERY OR CREMATORIAL <b>Good Shepherd</b>				22d. LOCATION (City, town, or county) <b>Ellicott City, Md</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				ADDRESS				24a. REC'D BY REGISTRAR DATE <b>APR 21 '58</b>				24b. REGISTRAR'S SIGNATURE <b>A. Leaven</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.  
APR 21 1938  
RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4676

## CERTIFICATE OF DEATH

04668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gulfport</i>		c. LENGTH OF STAY IN 1b <i>85 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. STREET ADDRESS <i>X Gulfport</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>GEORGE</i>		First <i></i>	Middle <i>Moore</i>
4. DATE OF DEATH <i>April 20 1958</i>		Last <i></i>	Month <i></i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>1873</i>		9. AGE (In years last birthday) <i>85 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>General Labour</i>		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) <i>Howard Co Md</i>		11. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George Moore Sr</i>		14. MOTHER'S MAIDEN NAME <i>Cassie Thomas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Henry Moore</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.2</i> DUE TO <i>Chronic Myocarditis</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>402 Main Street</i> (County) <i></i> (State) <i></i>	
21. I certify that I attended the deceased from <i>April 16, 1958</i> , to <i>April 20, 1958</i> , that I last saw the deceased alive on <i>April 19, 1958</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert S. McCeney</i> ADDRESS (Street, city or town, state) <i>Laurel, Maryland</i> DATE SIGNED <i>7/2/58</i>			
PHYSICIAN'S NAME (Type) <i>Robert S. McCeney, M. D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial April 23/58</i>		22b. DATE THEREOF <i>April 23/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Ashbury Cemetery Annapolis Junction</i>		22d. LOCATION (City, town, or county) <i>Road</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ridgley Kelly 401 W. Main St.</i>		ADDRESS <i>Laurel, Maryland</i>	
24a. REC'D BY REGISTRAR <i>APR 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alt. eugen</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK - DEPARTMENT OF  
CERTIFICATE OF DEATH

Attala

W.L.

Harrison

Jenning

82-94

Harrison

2-8 25 life 25 2-8

GEORGIA

1823-28

Whitehead

Thomas G. Jr.

Whitehead

James Johnson

Whitehead

John W. Clegg

Whitehead

BUREAU V. S.

APR 24 1958

RECEIVED

For filing in the Office of the Clerk and Sheriff of Harrison, New York  
This shall not be construed  
as a record

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4677

## CERTIFICATE OF DEATH

Reg. Dist. No.

04669

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE	
<i>Howard</i>		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
<i>Elkridge</i>	<i>33 yrs.</i>	<i>Howard</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>35 1/2 Main St</i>	<i>15512 Main St</i>		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>WEEMS</i>	<i>William</i>		<i>Sotheron</i>
4. DATE OF DEATH	Month	Day	Year
		3	1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>m</i>	<i>w</i>		<i>June 5 1880</i>
9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
<i>77</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Debt Maker</i>	<i>Retired</i>	<i>Elkridge Md</i>	<i>U.S.A.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Thomas Sotheron</i>	<i>Jennie</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
			<i>Mary Ruth Ryan 5503 Main St</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>350x</i>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)			
DUE TO			
(c) <i>Myocardial decompensation</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<i>Arthrosclerosis</i>			
DUE TO			
<i>Arteriosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Decubitus ulcer 2 mo</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1958</i> to <i>Apr 7 1958</i> , 1958, that I last saw the deceased alive on <i>Apr 7 1958</i> , and that death occurred at <i>Elkridge Md</i> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
DATE SIGNED			
<i>B.B. Brumbaugh M.D. 9602 Main St Elkridge 27 mo 4/15/58</i>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
<i>B.B. Brumbaugh</i>		<i>Elkridge 27 mo</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial Apr 7 1958</i>		<i>Grace</i>	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
<i>Grace</i>		<i>Elkridge Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Henry W. Jenkins Jr. 4905 York Rd</i>			
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<i>APR 7 1958</i>		<i>Outward</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4678

## CERTIFICATE OF DEATH

04670

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Ellicott City</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Folly Quarter Road</b>		d. STREET ADDRESS <b>Folly Quarter Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>LIZZIE SUPER</b>		First	Middle	Lost	4. DATE OF DEATH <b>April 28</b>	Month	Day	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-4-1869</b>	9. AGE (In years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Henry Super</b>			14. MOTHER'S MAIDEN NAME <b>Anne Ashenburner</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Henry Kursten, Ellicott City, Md</b>		Address		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Acute cardiac failure</b> DUE TO <b>420.0</b></p> <p>Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause lost. (b) DUE TO <b>Arteriosclerotic heart disease</b></p> <p>INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)</p> <p>(c)</p>								
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>								
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
<p>21. I certify that I attended the deceased from <b>Oct 24, 1957</b>, to <b>April 20, 1958</b>, that I last saw the deceased alive on <b>April 27, 1958</b>, and that death occurred at <b>7:30 P.M.</b>, from the causes and on the date stated above.</p> <p>ACTUAL SIGNATURE <b>Charles S. Witaker</b> M.D. ADDRESS (Street, city or town, state) <b>CLARKSVILLE, MD.</b> DATE SIGNED <b>4/29/58</b></p> <p>PHYSICIAN'S NAME (Type) <b>CHARLES S. WITAKER, M.D.</b></p>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-1-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Christ Church</b>		22d. LOCATION (City, town, or county) <b>Gulfport, Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>E.C. Higinbotham, Ellicott City, Md.</b>			ADDRESS			24a. REC'D BY REGISTRAR DATE <b>APR 30 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Al. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V.

APR 30 1968

RECEIVED